

**Operational Guidelines  
For  
Conducting  
Outreach Sessions in Urban Areas**

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**Ministry of Health & Family Welfare,  
Government of India**

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## Abbreviations

AD	Auto Disable (syringes)
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infections
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
CHC	Community Health Centre
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disease
CPMU	City Programme Management Unit
DPMU	District Programme Management Unit
DPT	Diphtheria, Pertussis and Tetanus
ECG	Electrocardiography
FHW	Female Health Worker
HIV	Human Immuno-deficiency Virus
HUPA	Housing and Urban Poverty Alleviation
IEC	Information, Education, and Communication
IFA	Iron and Folic Acid
IHSDP	Integrated Housing and Slum Development Programme
IUCD	Intra Uterine Contraceptive Device
JNNURM	Jawaharlal Nehru National Urban Renewal Mission
LHV	Lady Health Visitor
MAS	<i>Mahila Arogya Samiti</i> (Women's Health Committee)
MCH	Maternal and Child Health
MMU	Mobile Medical Unit
MO	Medical Officer
MOIC	Medical Officer In-Charge
MS	Medical Superintendent
MTP	Medical Termination of Pregnancy
NGO	Non Government Organisation
NHM	National Health Mission
NIDDCP	National Iodine Deficiency Disorders Control Programme
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
OCP	Oral Contraceptive Pills
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution

PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques (Act)
PHC	Primary Health Centre
PNC	Postnatal Care
PPP	Public Private Partnership
PPTCT	Prevention of Parent to Child Transmission
RAY	Rajiv AwasYojana
RCH	Reproductive and Child Health programme
RMP	Registered Medical Practitioners
Rs.	Rupees
RTI	Reproductive Tract Infections
RWA	Residents' Welfare Association
SHG	Self Help Group
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendants
UD	Urban Development
UHND	Urban Health and Nutrition Day
ULB	Urban Local Body
UPHC	Urban Primary Health Centre
WCD	Women and Child Development
VCTC	Voluntary Counselling and Testing Centre
VHND	Village Health and Nutrition Day
VVM	Vaccine Vial Monitor

# Foreword

## 1. Background

Urbanization is as one of the most significant demographic trends of the 21<sup>st</sup> century. Unplanned and rapid urbanization has led to massive growth in the number of urban poor population, especially those living in slums and other vulnerable locations in the city. . Migrants are drawn to urban areas to seek work opportunities and to establish a better life for themselves and their families. However, most Indian cities, from mega cities to small cities, lack the necessary infrastructure in terms of housing, water and sanitation, and basic services such as health care and education to accommodate and meet the needs of migrants, with serious implications for their health, wellbeing and productivity. Paradoxically therefore, cities can become hubs of marginalization , poverty and also, communicable & non-communicable diseases, unless appropriate policies & programmes are put in place.

The urban poor suffer from poor health status with higher burdens of mortality and morbidity and under-nutrition compared to rest of the urban population. Incidence of vector borne diseases, tuberculosis and respiratory infections is also significantly higher among the urban poor.

It is estimated that about a quarter of our urban population live in slums. Despite the supposed proximity of the urban poor to health facilities their access to them is severely restricted. Ineffective outreach and weak referral system also limit the access of urban poor to health care services. Social exclusion and lack of information and assistance at the secondary and tertiary hospitals make them unfamiliar to the modern environment of hospitals, thus restricting their access. The lack of economic resources inhibits/restricts their access to the available private facilities. Keeping in view the significant gap\* in availability of public health services in urban areas, the National Urban Health Mission was launched to address the primary health care needs of urban population.

The Framework of the National Urban Health Mission envisages the provision of outreach services targeted to the slum dwellers and other vulnerable groups. Unlike rural areas, sub-centers are not being set up in the urban areas as distances are small and transportation facilities are easily available. While routine outreach services will be provided through Female Health Workers stationed at Urban PHCs,, special outreach services will be organized for the vulnerable population as outlined in these guidelines.

### **Vulnerability Based Health Burdens of the Urban Poor:**

Urban populations and the urban poor are diverse and heterogenous. Hence, the vulnerabilities faced by the urban poor stem from their diverse and unique social, economic and geographic context, further impacting their specific health needs. In order to analyse the health needs of the urban poor, it is important to understand the various kinds of vulnerabilities faced by the urban poor. These include:

i) **Residential or habitat-based vulnerability:** Urban poor who are homeless, face insecurity of residential tenure, and do not have access to public services such as sanitation, clean drinking water and drainage and by virtue of their residential location, face residential vulnerability. This category includes those who live under road bypasses, on railway stations, under bridges and on footpaths.

ii) **Social vulnerability:** Persons who face marginalization on account of their social status based on caste, class, gender, age, disability are socially vulnerable. Examples include categories such as female-headed households, minor-headed households, the aged, and people with disability and illness.

iii) **Occupational vulnerability:** Persons who do not have access to regular employment, formal education or vocational skills and hence get 'locked into' informal and casual employment with irregular income are occupationally vulnerable. Groups such as head loaders, brick kiln workers, construction workers, manual scavengers, domestic workers are often exposed to unsanitary, unhealthy and hazardous working conditions with little safeguards for their personal and professional safety, and high potential for exploitation and discrimination.

These categories are not mutually exclusive, and it is observed that those who face one type of vulnerability will most likely also face the others, thus rendering them vulnerable on many fronts during their life span.

Urban populations have their own unique share of health and disease problems. . The urban poor are exposed to many hazards of urban life. With limited social and financial protection and in absence of an established system of Primary health Care delivery in urban areas, the health and development outcomes of urban poor are worse than that of rural population. This is evidenced by high levels of IMR, Child Malnutrition and low child immunisation coverage amongst urban poor in comparison to rural population. On account of overcrowding , poor water and sanitation facilities , urban slums are specially prone to vector borne and water borne disease epidemics. Stress and strains of urban life coupled with absence of traditional emotional and social support that is usually available to rural population, urban poor are likely to suffer from depression, substance abuse and other forms of mental health problems. High levels of air pollution in urban areas has given rise to high incidence of lung diseases in

children. Non Communicable Diseases like hypertension, diabetes and C.V.A. that are linked to unhealthy life style are on the rise in urban settings. Urban poor working as rag pickers, head loaders, sanitary workers etc face specific occupational hazards besides being exposed to the risks of injuries, violence and various forms of discrimination in a given society. Street children, homeless population, women working as domestic help far away from their place of residence and persons with disabilities are specially exposed to accidents , injuries and violence

#### **Access to Services:**

Urban population groups as described above have limited access to public health facilities in urban areas due to narrow range of available services and unsuitable working hours (8.00 am to 2.00 pm) observed by these facilities. Special vulnerable groups like rag pickers, sanitation workers, transgenders, those addicted to substance misuse including alcohol are not encouraged to use these facilities. They may take recourse to self –medication or services of unqualified local health practitioners.

Experiences from National Rural Health Mission (NRHM) demonstrate that strengthening health system at facility level alone may not bring about optimum results unless supplemented by “outreach service sessions” to extend the service coverage to those in need but not able or willing to visit health facilities to demand services. Essential package of services for pregnant women, children and those suffering from common morbidities have been made available through these outreach sessions.

## **2. Outreach Services in the National Urban Health Mission (NUHM)**

The framework of the National Urban Health Mission envisages a significant emphasis on enabling access to urban primary health services to the most vulnerable amongst the poor through outreach services:

*“Under the NUHM special emphasis would be on improving the reach of health care services to these vulnerable groups among the urban poor, falling in the category of destitute, beggars, street children, construction workers, coolies, rickshaw pullers, men and women suffering from physical violence, discrimination and exploitation, street vendors and other such migrant workers. Outreach services would target these segments consciously, irrespective of their formal status of resident ship etc.”*

#### **What are Outreach Services?**

Outreach is a critical function of primary health care. It serves to expand the reach and coverage of health services to urban poor population living in listed and unlisted slums and especially the vulnerable groups such as homeless, rag pickers, street children, migrants, men and women suffering from physical violence, discrimination and exploitation etc. A strong outreach program offers the best opportunity for the most vulnerable populations to be connected to and avail the basic medical facilities.

Service delivery in urban areas is expected to be organized through a network of Urban-PHCs and Urban-CHCs. Community based outreach sessions in the slums is the first step in the continuum of care approach linking primary to secondary and tertiary care services. Outreach services will be primarily targeted to the slum dwellers and other vulnerable groups.

The National Urban Health Mission (NUHM) provides support for outreach services that are targeted to slum dwellers and other vulnerable groups in towns and cities. Two types of outreach services are envisaged in NUHM: Urban Health and Nutrition Days (UHNDs) and Special Outreach Sessions.

While the Urban Health and Nutrition Day (UHND) are outreach sessions held on a monthly basis, Special Outreach Sessions are to be held weekly or fortnightly as per need of the State/UTs aiming to cover the homeless, construction workers, migrant population and other vulnerable groups apart from slum dwellers as per properly designed plan of action for implementation and follow-up. The outreach sessions (both UHND & Special outreach) could be organized at locations such as community structures, primary schools, anganwadi centers in coordination with ASHA and MAS members. Beside the above, infrastructure facilities like buildings constructed under the schemes of the Department of UD, HUPA, WCD, Social Welfare, RAY, IHSDP and JnNURM may be utilized as fixed points for providing periodic outreach services.

These guidelines are intended to serve as a road map for states to design and strengthen the UHND and Special Outreach Sessions. States are free to adapt these guidelines to the various contexts and sub populations for UHND and Special Outreach Sessions. Indeed, the adaptation is crucial especially in the case of special outreach sessions, because of variations in the nature of the sub-populations, the particular health and social needs of these sub populations and the availability of resources (financial and human) in cities/towns.

Mapping these populations and developing a systematic understanding of their health needs necessitates an understanding of the epidemiological profile of the local population, disease burden, and social determinants of health. These processes are fundamental to determining the approaches that States/UTs are able to implement to reach these particularly vulnerable groups. The resources required would go beyond those available through the NUHM. States are encouraged to leverage support from city corporations, philanthropic organizations, volunteer human resources from medical and nursing institutions, other academic institutions and civil society.

These guidelines were developed under the guidance of MoHFW (Urban Health) by the NHSRC with inputs from the states through consultative workshops and feedback on the draft document, members of the National ASHA Mentoring Group, and from representatives of the Population Foundation of India's Health for the Urban Poor programme.

## **Types of outreach services envisaged under NUHM:**

### **I. Outreach through Urban Health and Nutrition Days (UHND)**



The Urban Health and Nutrition Day (UHND) is a platform for people to access services for a package of preventive, promotive and basic curative care. It will be held at the Anganwadi Centre (AWC) or other suitable community spaces where such services can be provided on a regular basis. ASHA and MAS members are responsible for mobilizing the community and enabling access to services provided at the UHND. The UHND is intended as convergence platform for services to be provided by the ANM and Male Health Worker and the Anganwadi Worker (AWW). The UHND is also an occasion for health communication to create awareness in the community on a number of key urban health issues.

The UHNDs are expected to be organized along the lines of the Village Health and Nutrition Days (VHNDs) under NRHM. UHND would cater to slum populations within the catchment area of an Urban PHC (UPHC) and provide a set of preventive, promotive and simple curative services that are largely focused on Reproductive, Maternal, Newborn child and adolescents.

ASHA in collaboration with MAS will prepare the list of people requiring services to be provided by UHND. The date and location of UHND to be held in the area is shared in advance with ANM, AWW, and other local community leaders. Efforts will be made to ensure that marginalised, migrants and other vulnerable population groups requiring services are not left out. As mentioned earlier, ANM will ensure provision of essential RCH, contraceptive and immunisation services for women, children and adolescents. Simple curative services for minor ailments with appropriate referral arrangements will also be organised. Referrals and screening for NCDs like cancers, hypertension, diabetes, CVA, COPDs etc will be organised on annual basis. To extend the outreach of care, UHND should be held at locations that are distant from UPHC. Urban Local Bodies, School authorities, city health societies or other interested local community leaders may be contacted to provide building space/rooms for conducting UHND sessions. The MO/IC of the Urban PHC is responsible for development of an annual calendar for the UHND in her/his catchment area, reviewing the coverage and quality of UHND services delivered and timely submission of monthly and quarterly reports by ANM.

*The service package for UHND and checklist for responsibilities are provided in Annexures Ia and Ib.*

## **II. Special Outreach Sessions**

Special Outreach Sessions are expected to provide health care services specially to marginalised and vulnerable population groups in urban areas who may not present themselves to demand services from public health care agencies. Services provided through special Outreach Sessions would address their specific health needs with support from specialists, if needed

A few states have used Special Outreach Sessions to provide specialised services like screening for NCDs, including cancers, detection of development delays and childhood disability and dental and ophthalmic care. Simple diagnostic facilities (like blood and urine examination for sugar, Hb, albumin, malarial parasites detection etc) would also be provided by these sessions. Though the special outreach sessions are not designed to provide routine RCH services, these sessions should not miss the opportunity to provide these services to the needy. It is also recommended that the states should involve medical colleges and district hospitals to study

local disease burden, disease epidemiology and health needs and apply the learnings in better planning of Special Outreach Sessions

### 3. Planning and Implementing Special Outreach Sessions

- 1. Mapping the vulnerable:** The process of mapping enables identification of the vulnerable population groups so that they become visible to the health care system for better understanding and responding to their health needs. Mapping should also include community resources that could be mobilised for conducting outreach sessions ASHAs with support from MAS, ANM and AWW should carry out the mapping of local community resources and vulnerable populations
- 2. Community Volunteers:** Local community volunteers and social organisations like Rotaries, Lions, Residents welfare associations can provide valuable support to ASHA, MAS and ANM/AWW to carry out the task of organising outreach sessions, identifying vulnerable population groups and follow up on referrals and treatment compliance.
- 3. Involvement of Male Health Workers:** Many cities have sizeable populations of single male migrants with unique health concerns. Given our cultural context, women health workers may not be able to effectively reach out to these groups. Many states and city corporations involve male health worker in urban health care and support them through their own budget. As NUHM does not currently have provision of male health workers, they should be utilized in organizing routine and special outreach session in urban areas wherever they are available. Depending upon local situations and available resources, states may wish to involve male community volunteers also.
- 4. Involvement of field workers dedicated to control of Malaria, TB, Leprosy** in Urban areas may also be explored. In the case of Malaria, urban malaria program is operational with dedicated vector control workers in field, sanitary inspectors work as part of municipalities and corporations for malaria surveillance, or Male Health Workers of UPHC work at cluster level (covering 2 or 3 wards) to control spread of malaria.

Similarly, for TB, TB Health Visitor is placed to cover 1 lakh population each. Tuberculosis Units, Designated Microscopy Centre and DOT providers may also be located in urban areas to provide support to ASHA and ANMs to ensure diagnosis, treatment and follow up of suspected TB cases. ASHA gets incentive once the patient registered with her completes the course of treatment. Leprosy control in urban areas may have Non Medical Supervisors and Non Medical Assistants who monitor treatment and carry out field level activities. They are assisted in these tasks by ASHAs and ANMs.

Such existing workforce can be mobilized during outreach sessions.

- 5. Sites for organizing Special Outreach Sessions:** Special Outreach Sessions should be organized as close as possible to the habitations of the marginalized and vulnerable. The mapping process should also identify parts of the city where high concentrations of unorganised working populations exist like wholesale markets, land-fills, labour *addas*, railway and bus stations where such sessions can be held. Most public health facilities as

well as out-patient premises of medical colleges are usually vacant in the evenings. These spaces should be used for special outreach sessions, provided that geographic access is not a barrier.

- 6. Involvement of Union of Informal Groups (Occupational Vulnerable Groups):** It would be useful to involve trade unions and collectives of vulnerable groups, such as those of rickshaw pullers, construction workers, rag-pickers, women facing violence, exploitation and discrimination, , , disabled peoples collectives, organisations of the aged, homeless and street children to support the implementation of such session and build community ownership of such events
  
- 7. Involving Urban Local Bodies:** Such Special Outreach Sessions should seek active participation of the Urban Local Body (ULB) .This would ensure additional resources in terms of funds, space for conducting outreach sessions, mobility support, access to water and sanitation facilities and linkages with other development sectors like school education, nutrition and housing etc Special outreach sessions could also include services through “mobile clinics”. Mobile units, whose package of services would be similar to that available through special outreach, would provide services at a fixed date or time to unreached areas, such as remote slums, floating and migrant populations, and scattered homeless population groups.
  
- 9. Enabling access to referrals beyond health facilities:** To enable continuity of care, mechanisms should be established to refer these groups to supportive care facilities other than U-PHCs and U-CHCs. These may include: a) Free residential and out-patient Drug De-addiction Centres, b) Free residential mental health care recovery centre, c) Nutrition rehabilitation centres, d) Homeless recovery shelters, and e) Palliative care centres and hospices.
  
- 10. Supportive Supervision and Follow up:** While the responsibility for implementing the Special Outreach Session is with the UPHC, the overall supervisory responsibility is with the City/District health authorities. Supervision involves support to the UPHC in annual planning, allocation of resources, identification of specialists to be deployed, and monitoring the actual conduct of sessions in terms of coverage, quality and follow up. At the level of the UPHC, the MO would monitor each session held and ensure complete line listing of the catchment area, enable the provision of drugs and supplies and service coverage in terms of patients covered and referrals

*The service package of special outreach sessions and checklist for responsibilities are provided in Annexure IIa and IIb.*

These are explained in the table below:

**Table 1: Types of Outreach Services under NUHM**

	<b>Urban Health &amp; Nutrition Day (UHND)</b>	<b>Special Outreach Sessions</b>
<b>WHERE:</b>	Anganwadi Centre (AWC) or any other	Space or structure at the community level

	<b>Urban Health &amp; Nutrition Day (UHND)</b>	<b>Special Outreach Sessions</b>
<b>Site of providing the Service</b>	community level structure in slum	in slum/near vulnerable population (community centre, school which may be near railway station, railway tracks, city outskirts, bus stand, underpasses, outside place of worship, etc.).
<b>WHO: Population coverage</b>	Slum and vulnerable population (women and children) in the catchment areas of the UPHC	Vulnerable groups; emphasis on the most disadvantaged and hardest to reach (migrant labourers, homeless, etc.)
<b>WHAT: Service Coverage</b>	ANC, Immunisation, Health Education, Child Growth Monitoring, Nutrition Supplementation, Nutrition Counselling, education on Water Sanitation and Hygiene, Use of Rapid Diagnostic Kit, Drug Dispensing.	Health check-up (routine, for locally endemic diseases and population sub group specific problems), screening and follow-up (for chronic and non-communicable diseases), basic laboratory investigations (using portable /disposable kits), and drug dispensing
<b>BY WHOM:</b>	ANM supported by team of ASHA, AWW, and MAS members	Doctors/Specialists, Lab Tech, Pharmacist, physiotherapists, social workers,  Supported by MO-UPHC, with ANM and ASHA, MAS members and community volunteers
<b>WHEN: Frequency</b>	Monthly	Periodic (weekly/fortnightly)

#### **4. Financing/ Budget for the Outreach Services**

UHND services involve outreach by the ANM to different geographic sites within the catchment area of the UPHC. As the UHND are to be organized along the lines of the VHNDs, just as the VHSNC plays an active role in supporting the conduction of VHND, similarly MAS will play a key role in conduction of UHND in urban areas. Since "Routine Outreach" will be provided at the UPHCs and peripheral primary level health facilities in the urban areas (through the ANMs headquartered at these facilities) separate financial provision has not been made, except for Rs.500 per ANM per month as mobility support.

The consumables and supplies (like ORS, IFA, diagnostic test kits, etc.) for the UHND Routine Outreach will be provided through UPHC under the provision made under NUHM-RCH through UPHC, on the lines of VHND under NRHM. The RCH services to the women and children in slums would be provided through under Routine Outreach and UHNDs. For UHND, Rs250-Rs 300 per session will be made available. The cost may vary state to state.

The cost norms for Special Outreach Sessions vary from the routine UHNDs. The consumables and supplies for Special outreach sessions would be purchased as budgeted below.

#### **Cost norms for Special Outreach Sessions**

As both the UHND/Health Camps, are envisaged for slums and vulnerable population, it may be budgeted under the budget “Outreach Camps/Sessions”. The principle of differential allocation for each city/district will be followed, depending on utilization of funds. The MO I/C will decide as per the utilization status. The suggestive cost heads could be:

<b>Cost Head</b>	<b>Amount per session/camp (Rs.)</b>
<b>Doctors and Specialists</b> (outsourced, for paying their fees)	3,000/-
<b>Other paramedical staff</b> ( like Pharmacist, Lab Technician, etc. for paying their fees/incentive)	1,500/-
<b>Medicines, drugs and consumables</b> (including consumables for rapid diagnostic kits)	3,500/-*
<b>Transportation costs/conveyance allowance</b>	1,000/-
<b>Publicity</b> (loudspeakers, etc.)	1,000/-
<b>Per Special Outreach Camp/Session</b>	<b>10,000/-</b>

The above cost break-up is suggestive.

\* This can also be supplemented from the budget provided for supply of drugs to the UPHCs and UCHCs.

States can also pool their available resources to have dedicated teams to conduct special outreach camps and provide equipment such as ECG, X-Ray, basic lab diagnostic and other facilities and have dedicated team of doctors, paramedics and vehicles etc. States and city corporations may enter into partnership with medical colleges, not for profit/ charitable organisations and with private sector for conducting special outreach sessions. Municipalities and corporations can also put additional funds from their budgets for conducting outreach sessions. Local volunteers, youth clubs, MAS, women’s SHG groups can also be involved in organizing the camps.

Estimates suggest that the slum population in a catchment area of a UPHC would be around 25% and other vulnerable population would be an additional 10% of the urban population. The funding support for IEC includes the cost of mobilization and publicity to generate widespread awareness by ASHA, AWW, and MAS members on the objectives of the camp and services available.

# **ANNEXURES**

**(Organising Special Outreach/UHND for Slums and Urban Vulnerable Populations)**

## Annexure I(a)

### Service Package at Routine UHND

The UHND will cover women and children living in slums and among other vulnerable population. The service will be provided on monthly basis by the ANM in coordination with ASHA and Anganwadi Worker (AWW) at a community structure in slum/near vulnerable population (like Anganwadi Centre, School, Railway Station, Bust Stand, place of worship, etc.). The package of services will include the following:

#### (a) MATERNAL HEALTH

- Pregnancy testing, and Early registration of pregnancies
  - Provision of full complement of ANC services with quality and accuracy
- Completed Mother and Child Protection Card
- Referral for women with signs of complications during pregnancy and those needing emergency care.
- Referral for safe abortion to approved MTP centres.
- Counselling on a range of topics such: Education of girls, Age at marriage. Care during pregnancy, Danger signs during pregnancy, Birth preparedness, Importance of nutrition. Institutional delivery, awareness of the JSY and JSSK schemes, Post-natal care. Breastfeeding and complementary feeding, Care of a newborn, and Contraception.
- Organizing Maternal and infant death reviews.

#### (b) CHILD HEALTH

For Infants up to 1 year: Registration of new births, Counselling for care of newborns and feeding, Complete routine immunization, Immunization for dropout children, First dose of Vitamin A along with measles vaccine, Weighing.

For Children aged 1-3 years: Booster dose of DPT/OPV, Second to fifth dose of Vitamin A, Tablet IFA - (small) to children with clinical anaemia, Weighing, Provision of supplementary food for grades of mild malnutrition and referral for cases of severe malnutrition.

For all children below 5 years: Tracking and vaccination of missed children by ASHA and AWW, Case management of those suffering from diarrhoea and Acute Respiratory Infections, Counselling to all mothers on home management and where to go in even of complications, Provide ORS packets, Counselling on nutrition supplementation and balanced diet, Counselling on and management of worm infestations.

Adolescent Health (Age group 10-19 yrs)- Health and counselling needs of adolescents especially Males should also be addressed. This may include advice against substance abuse, promoting healthy life style and responsible sexual and social behaviour and practices

#### (c) FAMILY PLANNING

Information on use of contraceptives, Distribution - provision of contraceptive counselling and provision of non-clinic contraceptives such as condoms and OCPs, Information on compensation for loss of wages resulting from sterilization and insurance scheme for family planning.

#### (d) REPRODUCTIVE TRACT INFECTIONS AND OTHER RELATED CONDITIONS

The service may include counselling on prevention of RTIs and STIs, including HIV/AIDS, and referral of cases for diagnosis and treatment. Other important areas include information on transmission and prevention of HIV/AIDS and distribution of condoms for dual protection., Referral for ICTC and PPTCT services to the appropriate institutions will also be carried out

#### (e) HEALTH PROMOTION

- Nutrition issues: Focus on adolescent pregnant women and infants aged 6 months to 2 years, Checking for anaemia, especially in adolescent girls and pregnant women; Checking, advising and referring for other deficiency disorders (Vitamin-A, Iodine-deficiency, Protein Calorie Malnutrition, etc.), Weighing of infants and children, Supply of iron supplements, vitamins, and micronutrients.
- Importance of clean drinking water, safe water handling practices, use of long handle ladle, and ways to keep the water clean at point-of-use, using chlorine tablets, boiling, water filters, etc.
- Education on Healthy food habits, hygienic and correct cooking practices, and hand washing.
- Testing of household salt sample for Iodine (using the testing kits supplied under NIDDCP programme)
- Avoidance of breeding sites for mosquitoes.
- Mobilization of community action for safe disposal of household refuse and garbage.
- Gender issues: Communication activities related to PCPNDT, Communication on the Prevention of Violence against Women and Children, Domestic Violence Act, 2006, Age at marriage, especially the importance of appropriate age at marriage for girls, Issues of Alcohol and drug abuse, tobacco and gender violence, A discussion about and review of the AWC's daily activities at the centre, supplementary nutrition services being provided for children and pregnant and lactating mothers, and growth charts being recorded at AWC.
- Sanitation issues: Identification of space for community toilets, Guidance on where to go and who to approach for availing of subsidy for those eligible to get the same under the Jawaharlal Nehru National Urban Renewal Mission (JNNURM).



## Annexure I(b)

### Checklist for Responsibilities and Functions for UHND

#### MOIC (at the UPHC)

- Develop a calendar for UHND and designate geographic areas for where it is to be held, ensuring complete coverage in the catchment area and familiarizing each member with the calendar.
- Coordinate with the CDPO and ICDS Supervisors for availability of the Anganwadi Centre and the Anganwadi Worker.
- Dialogue with ULB representatives (Ward member) on availability of community centres and other alternative facilities, along with support for the cleanliness, water, security and other support required at the site.
- Ensure that the supplies of drugs, vaccines and consumables reach the site well before the day's activities begin.
- Ensure reporting of the UHND to the UCHC and City/District PMU (as per format suggested in Annexure IV).

#### ANM

- Ensure that all ASHA know where the UHND is to be held
- Ensure that the supply of vaccines reaches the site well before the day's activities begin.
- Ensure that all instruments, drugs, and other materials as listed in the annexure are in place.
- Ensure reporting of the UHND to the MO in charge of the Urban PHC (UPHC) (as per format suggested in Annexure IV).
- Coordinate with the ASHA and the AWW.

#### Anganwadi Worker (AWW)

- Ensure that the Anganwadi Centre (AWC) is prepared for the UHND (if it is to serve as the site for UHND).- cleanliness, water supply, privacy for ANC/PNC,
- Coordinate activities with the ASHA and the ANM.
- Provide the Supplementary Nutrition and Take Home Ration (THR) and ensure arrangements for growth monitoring.

#### ASHA

##### Actions to be taken before the UHND:

- Visit **all** households and line list women and children needing UHND services.  
- ANC, Immunization, Malnourished children, and particularly focus on those that were missed/drop -outs
- Ensure publicity of the event (as per Annexure V).

##### On the day of UHND:

- Ensure that all listed women and children report to the health centre and receive services.
- Ensure participation by MAS members.

## **Annexure II(a)**

### **Service Package at Special Outreach Sessions**

Special Outreach Sessions will cover the most vulnerable and marginalised groups with special attention to their specific health needs. The package of services may include the following:

(a) Curative services:

- Specialist Services such as Obstetric/Gynaecology, Paediatric, Dermatologist, Dental and other special services.
- Early detection of TB, Malaria, Leprosy, Kala-Azar, and other locally endemic communicable diseases and non-communicable diseases such as hypertension, diabetes and cataract cases;
- Minor surgical procedures and suturing; (Depending on the location of the camp)
- Referral of complicated cases;

(b) Diagnostic services:

- Investigation facilities like haemoglobin, urine examination for sugar and albumin;
- Screening for Hypertension, Diabetes and COPD
- Vision screening
- Blood counts
- Urinalysis
- Clinical detection of leprosy, tuberculosis and locally endemic diseases;
- Screening for breast, cervical and oral cancers etc.
- ECG

(c) Preventive and Promotive services –If needed, routine RCH services may also be organised as discussed under routine UHND

(d) Every chronic patient (such as diabetic, hypertensive or suffering from Chronic obstructive Pulmonary Disease (COPD) should be provided with a health card. It must be ensured that these patients are provided with essential medicines and clinical advice on a continuous basis.

## Annexure II (b)

### Checklist for Responsibilities and Functions for Special Outreach

#### MOIC (at the UPHC)/Public Health Manager

- City Program Management Unit/State Program Unit to prepare calendar for UHND and designate geographic areas for where it is to be held, ensuring complete coverage in the catchment area and familiarizing each member with the calendar.
- Ensure that the Special Outreach/Health Camp is held on the stipulated day and time and also ensure the presence of the required health functionaries.
- Coordinate with U-CHC/City-PMU/District-PMU for deputing MOs, Specialists, LTs and Pharmacists for the Special Outreach/Health Camp. Make alternative arrangements with the private providers, in case government providers are not available.
- Ensure that adequate money is available for disbursement to the private providers, wherever they are engaged on a daily basis.
- Ensure that the supply of diagnostic kits, equipment, drugs and consumables reaches the site well before the day's activities begin.
- Ensure reporting of the Special Outreach/Health Camp to the U-CHC and City/District PMU (as per format suggested in Annexure IV).
- Dialogue with ULB representatives (Ward member) on availability of community centres and other alternative facilities, along with support for the cleanliness, water, security and other support required at the site.

#### ANM/Male Health Worker (wherever available)

- Ensure that the supply of diagnostic kits, equipment, drugs and consumables reaches the site well before the day's activities begin.
- Carry communication materials.
- Ensure reporting of the special outreach to the MO in charge of the Urban PHC (UPHC) (as per format suggested in Annexure IV).
- Coordinate with the ASHA and the AWW to ensure publicity of the event, mobilization of the vulnerable groups and follow up.
- Ensure publicity of the event as per Annexure V.

#### ASHA/ MAS/ other community groups (like SHG)/Local Volunteer

##### Actions to be taken before the Special Outreach:

- Visit all households and make a list of most vulnerable and marginalised identified with the help of vulnerability assessment tool. Dialogue with MAS members on mobilization support required from the community.
- Make a list of children with special needs, particularly girl children.
- Make a list of persons suffering from cough for more than 3 weeks.
- Coordinate with the AWW and the ANM.
- Share the calendar of Special Outreach/Health Sessions (if applicable), and the date / day of next camp
- Ensure publicity of the event (as per Annexure V).
- Identify persons having symptoms of mental illness such as depression, anxiety, social withdrawal etc.

## Annexure II [c]

### Population groups/ households to be targeted for special outreach camps

Tick if you find the households/families/population groups falling in any of these categories:

- Rag Picker
- Rickshaw puller
- Head loaders
- Construction workers
- Daily wage laborers
- Homeless
- People involved in Begging
- Domestic workers
- Elderly poor
- Widow/deserted women
- Women/child headed household
- Differently Abled
- Debilitating illnesses- HIV/AIDS, TB, Asthma, Diabetes, Leprosy etc.
- Women suffering from physical violence, discrimination and exploitation
- Street Children
- Trans-genders
- Sanitary workers
- People with mental illness
- People living in institutions like night shelters, homeless recovery shelters, beggars home, leprosy homes
- Household with severely acute malnourished child and or an infant without mother or caregiver.
- Household having no access to sanitation & water supply
- Slum dwellings near hazardous location (dumping ground, footpath, railway track, fly-overs, under bridge)
- Any other, Please specify \_\_\_\_\_

## Annexure II (d)

### Guidelines to use checklist to identify vulnerable households for special outreach camps:

The above checklist is to identify vulnerable populations groups by the ANM or ASHA in her routine outreach visits. Broad guidelines provided below give an understanding of 'vulnerable groups'. While providing care services, one must address patients concerns in terms of prompt attention, acceptance, respect, dignity, sensitivity and confidentiality.

**Rag pickers:** With a lack of solid waste disposal management system in most cities in India, rag-picking is a common vocation among many vulnerable families and street children. They collect and sort recyclable waste materials such as plastics and metals from the public dustbins roads, parks, railway tracks and landfills. Most of these children are slum dwellers or from economically extremely poorer sections, who take to this occupation as a means of survival or supplementing family income. Usually working barefoot and without adequate tools to deal with extremely hazardous materials, these children are vulnerable to injuries, accidents and infections. They are often also exposed to substance abuse and have little access to health care, education, and other support services.

**Street children:** A street child is someone for whom the street has become the 'habitual home' and a source of livelihood and who is inadequately protected, nurtured, supervised and directed by responsible adults. Mostly these children are orphans, abandoned or have left their families to take up odd jobs such as rag picking, begging, cleaning the railway bogies, etc. Some of them have no other choice but to spend night using shelter homes run by the government or NGOs. These children are highly vulnerable to infection, road side injuries, physical violence and substance abuse.

**Child-headed household:** It is a household managed by child, without presence of any elder member of family above 18 years) to provide financial or emotional support. Such households are highly vulnerable as their members ( children less than 18 years) are required to work as child labours under exploitative market conditions to make both ends meet. They also face multiple deprivations in terms of inadequate access to health care, education and social protection

**Single women:** Single women, whether living alone, or with dependents face vulnerability on account of gender discrimination, physical and economic exploitation at workplace and difficulties in accessing social protection and health care schemes. Single women may be widowed, unmarried, separated or deserted and may in many instances face additional responsibility of supporting dependent parents and children. Thus they face multiple deprivations and vulnerabilities.

**Women suffering from physical violence, discrimination and exploitation:** Women in our society encounter gender inequalities which may manifest in many forms of discrimination right from women's womb with sex determination and female foeticide, sex selective abortions etc. Discrimination of girl child on many fronts of nutrition, education, employment make them vulnerable. Evidence shows that discrimination of women could be in terms of access to public resources including education, health care and social protection services.. Further women, in general from poorer sections may also face domestic violence, sexual exploitation at work place and economic hardships. Anxiety, depression and suicidal tendencies are common but serious mental disorders affecting these women. ASHAs and Health Workers must try to understand the difficult circumstances surrounding these women and take steps to provide emotional and health care support to ameliorate the situation

**Transgenders:** : Commonly known as 'Hijras', persons in this category have a gender perception about themselves that does not match with conventional image and roles assigned to males or females. . For example an individual with male genital organs from birth, is regarded as male by the society but the concerned individual declines to identify himself with this perception and prefers to behave and assume the role of opposite gender that is, of a female . The sexual preferences and orientations of transgenders are at variance with conventional societal perception. Transgenders face a lot of stigma and discrimination in society. They also have limited access to health care and educational facilities and often face economic hardships. In view of almost non-existent employment opportunities, members of this group take to odd jobs like begging, dancing and selling sex . As a consequence, they are exposed to physical and sexual violence, sexually transmitted diseases and mental disorders. ASHAs and Health Workers need to adopt very supportive and sensitive approaches to organise special outreach sessions to ensure participation of transgenders and utilisation of health care services offered ,

**Differently abled:** Persons with physical and mental disability face multiple vulnerabilities on account of limitations in physical movements, visual capacity,, vocational options, level of dependence on others and special health needs. Multiple co morbidities may also occur in differently abled persons requiring specialists care and referrals. Physical disability and poverty are inter linked and therefore persons in this category face multiple vulnerabilities and deprivations

**Debilitating illnesses- HIV/AIDS, TB, Asthma, Diabetes, Leprosy:** During outreach visits to families, persons with HIV & AIDS are generally 'invisible', as there is stigma associated with the disease.. The ANM/ASHA should equip herself with basic knowledge and counselling skills needed to deal with HIV/AIDS cases in community. Similarly, cases of Diabetes, Tuberculosis and leprosy existing in a given family should be identified by the Health Workers during their domiciliary visits to ensure referrals to UPHC and treatment compliance

**Rickshaw pullers, construction workers, head loaders:** This group consists of urban poor and slum dwellers who are daily wage earners and unskilled labours engaged as construction workers, manually carrying heavy loads of goods and passengers as rickshaw pullers. Most of them are migrants from rural areas and do not possess any identity card and hence have very limited access to health care and social protection services. They have come to cities in search of livelihood, leaving their families behind and face vulnerabilities on multiple fronts.

**Domestic workers:** In cities, many poor women work as domestic help workers earning low monthly salaries and putting in long working hours daily. This is an unorganised sector employing a substantial number of poor women to support household chores and serve as helpers to house wives and working women in cities. These women do not have easy access to health care or social protection services. They are also vulnerable to physical violence, sexual exploitation and economic hardships

**Homeless/Houseless:** As per the census definition, houseless population groups are those who do not live in buildings or census houses, but live in the open on roadside, pavements/footpaths, under flyovers and staircases, open government lands or in the open places/premises of worship, railway tracks, canal banks, etc. They can be living in single or in families. They are vulnerable to a gamut of health related problems, including trauma from accidents, violence, attacks etc, apart from ailments arising out of lack of basic facilities such as

safe drinking water and sanitation. Slum dwellers near hazardous locations such as dumping grounds may also be prone to sanitation related diseases or vector borne diseases, apart from others. This segment also includes persons living in shelters (could even be night shelters) for the homeless run by charities, religious institutions and government. Health workers, ASHAs and AWWs under the guidance of Medical Officer may wish to carry out a rapid survey to find out the morbidity profile and health care needs of this population group Organisation of special outreach sessions should be duly informed by findings of such surveys

**People living in institutions** Destitute women, elderly in old age homes, prisoners, juvenile offenders and mentally ill living in institutions face a range of vulnerabilities – firstly on account of their social status and social stigma attached to those who are compelled to stay in institutions and secondly on account of the poor living conditions in the institution. It has been noted that institutionalized persons face violence and discrimination perpetrated by caretakers of the Institutions. There are also occasional reports of rapes and sexual violence, misconduct, poor nutrition and unhygienic living conditions rampant in the institutions. In a few institutions, health care check ups and services are organised for inmates but there is a strong need for these institutions to collaborate with the nearest UPHC to improve the quality and coverage of health care services for inmates.

**Elderly poor:** This is a highly vulnerable group in the urban settings and amongst this group elderly women are more vulnerable. The life in cities is hectic and every adult member of the family is busy to make both ends meet and earn money for the family. Hence the old and dependent members of the family are left to fend for themselves. Elderly persons staying alone in their houses in urban areas face personal security problems. Physical, social and economic dependence render them vulnerable on many accounts. Besides, they also suffer from disease commonly found in old age like cataract, diabetes, osteoarthritis, hypertension, stroke and COPD. The old people in urban settings, and in absence of social protection and emotional support are susceptible to psychiatric disorders like depression, Alzheimer’s disease, anxiety, and suicidal tendencies. ASHAs and health workers should be knowledgeable and sensitive to the special health and emotional needs of elderly persons and accordingly make arrangements to address them through special outreach sessions and follow up with referral support and treatment at UPHC.

**Households with severely / acute malnourished child and or an infant without mother or caregiver:** severely/ acute malnourished children could be a common sight in the slums or slum like settlements in urban areas. Children with visible signs of stunted growth, wasting and some deficiencies in visible forms of depigmentation/skin patches, copper coloured hair, liver enlargement, swollen feet, or emaciated body etc., can be given adequate information about the need for treatment and in consultation with the MO/UPHC referred to Nutrition Rehabilitation Centres (NRC) depending upon the age group of the child and the severity of the condition. It is important to keep in mind that hospitalization may be needed in severe cases of malnutrition. Health workers and ASHAs should be able to identify and enlist children suffering from severe acute malnutrition in their areas and ensure that proper treatment and follow up care is organised through special outreach sessions, UPHCs or Nutrition Rehabilitation Centres or through hospitals

In a household , an infant without mother or a care giver is at special risk of dying and health workers and ASHAs must enlist all such children for intensive follow up and care through special outreach sessions and referrals to UPHCs

## Annexure III Reporting Formats

### a. Reporting Format for UHND

Date of UHND: \_\_\_/\_\_\_/\_\_\_

1. Name of the Urban PHC (UPHC): \_\_\_\_\_
2. Locality/Slum name: \_\_\_\_\_
3. Place where UHND held: \_\_\_\_\_ (AWC, school, any other – please specify)

### B. SERVICE STATISTICS

1. Total No. of women who received treatment:
2. Total no. of children who received treatment:
3. No. of pregnant women checked up for ANC:
4. No. of pregnant women immunized with TT:
5. No. of pregnant women with complications referred to higher facilities:
6. No. of Children vaccinated:
7. No. of women motivated and referred for IUCD:
8. No. of women motivated and referred for sterilization:
9. No. of men motivated and referred for sterilization:
10. No. of severely malnourished children identified, counselled and referred to higher facilities:

11. *Any other services:*

12. Line list of all the individuals with name, diagnosis and follow-up who attended the camp attached: YES/NO

### C. VERIFICATIONS

Name & Sign of ANM: \_\_\_\_\_  
Name & Sign of AWW: \_\_\_\_\_  
Name & Sign of ASHA: \_\_\_\_\_  
Name & Sign of Public Health Manager: \_\_\_\_\_

**Please note:** ANM and ASHA should line list all the individuals with name, diagnosis and follow-up who attended the camp and attach the list with this report.

Name & Sign of MO-I/C: \_\_\_\_\_



## b. Reporting Format for Special Outreach Sessions

Date of Session: \_\_\_/\_\_\_/\_\_\_

1. Name of the Urban PHC (UPHC): \_\_\_\_\_
2. Locality/Slum name: \_\_\_\_\_
3. Place where session was held: \_\_\_\_\_
  
4. No of specialists attended (indicate government and outsources specialists separately)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
5. Number of individuals who received treatment in the camp: \_M\_\_\_\_\_ F \_\_\_\_\_
6. No of children who received treatment in the camp \_\_\_\_\_
7. Number of individuals diagnosed/screened with the disease (specification/condition wise): \_\_\_\_\_  
TB: \_\_\_\_\_
8. Diabetes Mellitus: \_\_\_\_\_  
Hypertension: \_\_\_\_\_  
COPD: \_\_\_\_\_  
Cervical cancer: \_\_\_\_\_  
Others: \_\_\_\_\_
  
9. Number of individuals referred to higher centre/ alternative referral unit:  
\_\_\_\_\_
10. No. of follow up cases attended: \_\_\_\_\_
11. No. of persons provided diagnostic services : X-Ray \_\_\_\_\_, ECG \_\_\_\_\_,  
Blood glucose \_\_\_\_\_, B.P. \_\_\_\_\_, others \_\_\_\_\_;
12. Line list of all the individuals with name, diagnosis and follow-up who attended the camp attached: YES/NO
13. Approximate quantity and value of drugs distributed \_\_\_\_\_  
\_\_\_\_\_

### C. VERIFICATIONS

Name & Sign of ANM: \_\_\_\_\_

Name & Sign of AWW: \_\_\_\_\_

Name & Sign of ASHA: \_\_\_\_\_

**Please note:** ANM and ASHA should line list all the individuals with name, diagnosis and follow-up who attended the camp and attach the list with this report.

Name & Sign of MO-I/C: \_\_\_\_\_

**c. Deliverables/ Monthly Reporting**

1. Total No. of sessions organized in month: \_\_\_\_\_  
UHND: \_\_\_\_\_  
Special Outreach sessions: \_\_\_\_\_
2. No. of pregnant women provided ANC & PNC services: \_\_\_\_\_
3. a. No. of children provided immunization \_\_\_\_\_
- b. No. of Sick Children provided health care services: \_\_\_\_\_
4. Total OPD & referral: \_\_\_\_\_
5. Lab tests conducted: \_\_\_\_\_
6. Details of specialist services provided: \_\_\_\_\_
7. Line list of all the individuals attended the camp with name, diagnosis and follow-up attached: YES/NO

## **Annexure IV**

### **Publicity**

#### **KEY COMMUNICATION OBJECTIVE**

To make the community, especially women from vulnerable sections and other stakeholders in the community, aware of service availability on fixed days at AWC.

#### **WHOM TO INVOLVE**

4. ASHA
5. MAS members
6. Members of local RWAs/Mohalla Sabhas
7. Ward members
8. SHG members
9. Teachers and other community leaders
10. School children
11. Beneficiaries
12. Traditional Birth Attendants (TBA) and other Registered Medical Practitioners (RMP)

#### **MEDIA AND METHODS**

- Wall writings in the local language
- Hoardings at one or two prominent places in the locality
- Handbills and pamphlets

Resources for publicity activities can also be accessed through the IEC fund made available and untied funds available with the Urban PHC, in addition to the amount indicated in the guidelines. ASHA can help and facilitate in this whole process at different levels.